

The four papers that follow discuss the impact on group practice prepayment plans of the Social Security Amendments of 1965, particularly Medicare and Medicaid, and of the Economic Opportunity Act of 1964. Although only selected aspects and programs are presented, more general questions concerning the role and responsibility of such plans are raised.

GROUP PRACTICE PLANS IN GOVERNMENTAL MEDICAL CARE PROGRAMS

I. GROUP PRACTICE PREPAYMENT PLANS IN THE MEDICARE PROGRAM

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Introduction

THE adaptability of Americans and their institutions is sometimes doubted. There were often moments of doubt among the Group Practice Prepayment Plans (GPPPs) during the early months of the Medicare program—doubt that either they or the Social Security Administration (SSA) could find ways to adapt their unique patterns of operation to the requirements of Title XVIII, Public Law 89-97. As one looks back over the almost two and a half years of Medicare, it is clear that the plans, which chose to deal directly with SSA on a reasonable cost basis for supplementary medical insurance (Part B) covered services, and the SSA have managed to evolve a workable, if not ideal, series of arrangements. These were accomplished within the framework of a law which, while recognizing the GPPPs, was by no means designed to accommodate them.

Legislative Basis

Section 1833(a)(1) of the Social Security Act provides in part that: "... an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 per cent of the reasonable cost of services. . . ." The type of organization which may elect this option is referred to by the Senate Finance Committee as a group practice prepayment plan. In its report, the committee reasoned: "The committee bill would provide group practice prepayment plans with the alternative of having the program pay 80 per cent of the reasonable cost of the covered services they furnish (including physicians' services) rather than 80 per cent of the reasonable charges. The committee believes this change is desirable to accommodate group practice prepayment plans. . . ."

Thus, the legislation carried over into the supplementary medical insurance (SMI) program the concept of reasonable cost, which is the basis for payment in the hospital insurance (HI) program. This concept of payment was in general accord with the fundamental prepayment concepts of the group practice prepayment plans. In other words, payment would be on a current basis for the reasonable cost of having available and providing as needed all or a specified portion of the medical care services covered under the SMI program.

GPPP Participation in Medicare

To be eligible to participate in the SMI program on the basis of reasonable cost, a group practice prepayment plan must be an organization that has a formal arrangement with the equivalent of three or more full-time physicians to provide specified medical care services to the plan's membership. This medical group may not be composed entirely of general practitioners. The plan's membership must be identified as to those below and above age 65. A number of administrative reasons prompted this requirement, but principally it enables the plan to carry out the requirement that it keep the records needed to make correct allocation of costs between aged and younger members.

Sixty-eight GPPPs were initially identified by the Social Security Administration as potentially conforming to these general specifications. GPPPs may be classified by sponsorship into three categories: community; employer-employee-union; and physician-sponsored plans. Community or employer-employee-union-sponsored plans may employ directly, on a salaried, retainer, or similar basis, physicians and dentists to provide care to participating persons in facilities usually owned and maintained by the plan. Employer-employee-union-sponsored plans tend to favor this type

of arrangement. On the other hand, community- and union-sponsored plans may contract with one or more independent groups of physicians or dentists, generally organized as partnerships, which agree to provide specified services in the plan's and/or their own facilities to participating persons in return for a specified remuneration. Community-sponsored plans tend to favor this type of arrangement. Physician-sponsored group practice prepayment plans generally offer their services to groups of patients on a prepayment basis and to individual patients on a fee-for-service basis.

Of the 68 GPPPs identified by SSA in 1966, 70 per cent were employer-employee-union-sponsored; 20 per cent were community-sponsored; 10 per cent were physician-sponsored plans. Forty-two plans,* the bulk of them employer-employee-union-sponsored, elected to be reimbursed through area carriers on the basis of reasonable charges. Twenty-six plans* chose to be reimbursed directly by SSA on a reasonable cost basis; three plans had ceased operations by July 1, 1967.†

The 23 GPPPs that continue to be reimbursed directly by SSA represent all three types of plans. Eight are community-sponsored, 13 are employer-employee-union plans, and two are physician-sponsored. The combined total membership of these plans, totaling about three million persons, represents an estimated 75 per cent of the enrollment in all GPPPs.

There were about a quarter of a million enrollees aged 65 and over in these 23 plans representing 8.3 per cent of their aggregate membership—somewhat less than the 9.5 per cent aged in the United States. The number of aged enrollees relative to total enrolled mem-

* 1st Annual Report on Medicare, House Document No. 331, 90th Congress, 2nd Session, Gov. Ptg. Office.

† These three plans were hospital-based plans serving employees of the railroad industry.

bership was generally low in community-sponsored plans, averaging 5 per cent. In sharp contrast, employer-employee-union plans averaged 20 per cent and the physician-sponsored plans 16 per cent aged enrollees.

As of July 1, 1967, of some 17.9 million persons enrolled in the SMI program, the 250,000 aged enrollees in these 23 GPPPs represent 1.4 per cent.

Reasonable Cost Basis of Reimbursement

The policies that established the guidelines and procedures for use by group practice prepayment plans for reimbursement on the basis of 80 per cent of the reasonable costs of the covered services furnished, considered the variations in size, scope of services, and organizational patterns of the plans. Thus, the guidelines are necessarily flexible. They provide options to accommodate individual circumstances and allow for variations in the accumulation of statistical and financial data.

Reasonable cost as it relates to group practice prepayment plans is further defined as the proportionate share of the cost of providing or making available covered services to enrolled beneficiaries. Thus, the share of the plan's total costs that is borne by Medicare is related to the services furnished Medicare beneficiaries so that no part of these costs are borne by the other enrollees of the plan. To accomplish this, provision was made to allow a plan to determine from its own records a ratio of time and utilization factors between its Medicare enrollees and its other enrollees as a basis for allocating costs. This provision also eliminated any subsidization of older enrollees by the younger enrollees of the plan for costs intended to be covered by the Medicare program.

Allowable Costs

Reimbursement is made to each plan for covered medical care services furnished its beneficiary enrollees, including

cost of the medical services provided by physicians and expenses for clerical, technical, and other professional personnel necessary to provide covered services. Other covered medical costs may be incurred by a plan for "purchased services," such as radiology, anesthesiology, pathology, or physiatry services in the hospital or clinic; services of "superspecialists" for procedures such as open heart or brain surgery and emergency services in or out of the service area of the plan. Since these costs cannot be precisely determined in advance, they are subject to retroactive adjustment on the basis of actual experience.

A plan would also include, where applicable, depreciation based on asset costs, interest expenses, value of services for nonpaid workers under specified circumstances, and so on. Such costs as well as allowable administrative costs, are prorated between beneficiaries and nonbeneficiaries on a per capita basis.

Costs for services specifically excluded by law, such as routine physical checkups, dental care, eye examination for fitting of glasses, are not reimbursable. Similarly, administrative costs applicable to noncovered services and operating costs not related to patient care (e.g., expenses incurred in solicitation of enrollment) are not reimbursable.

Computation of Value of Deductible Amount

The \$50 annual deductible and the 20 per cent co-insurance features of Title XVIII are essentially fee-for-service concepts. Adaptation of the 20 per cent co-insurance requirement to a maximum premium charge for enrolled beneficiaries of 20 per cent of reasonable cost was relatively simple. However, the annual \$50 deductible with its complicating "carry-over"* provision required

* Any expenses incurred by an individual in the last three months of a calendar year and applied to the \$50 deductible for that year may be carried over and applied to the deductible for the next calendar year.

the development of a computed "average" annual deductible since GPPPs generally do not have a charge (or cost) for each service provided to each enrollee. A variety of methods for computing the "average" value of the deductible based on the plan's own records was suggested. For plans not having adequate data, a standard amount (\$23 in 1966, \$30 in 1967-1968) was allowed. The computation of the "average" annual deductible and its equitable application continues to present some difficulties both for the plans and SSA. However, the quarter of a million aged enrolled in GPPPs are entirely relieved of the problem of trying to understand the carry-over feature of the deductible. Nor do they need to keep records necessary to determine when they have met the deductible and can expect to be reimbursed for 80 per cent of reasonable charges.

Limitation of Charges to Beneficiaries

Section 1833(a) (1) of the Social Security Act provides that a group practice prepayment plan electing to be reimbursed on the basis of reasonable cost may charge its Medicare enrollees for: (1) the allowable annual deductible (preferably a computed weighted average amount, as already noted); (2) no more than 20 per cent of reasonable costs for covered services after first subtracting the deductible; and (3) an amount considered necessary to cover costs of services for which no payment may be made under the Medicare program (e.g., routine physical checkups; eye examinations for glasses). These amounts are estimated by the plan at the beginning of the year. The charge is usually a monthly premium payable by each enrollee. At the end of the year, the total accrued charges are compared with the corresponding total deductible and the allowable 20 per cent of reimbursable costs, each computed by the

plan on the basis of actual costs during this period. If the total charges paid by Medicare enrollees during the year exceed the allowable costs computed from accounting records at the end of the year, an adjustment is required of the plan. The adjustment may be made by means of one or a combination of the following methods, after first advising the Social Security Administration in writing which method(s) would be used:

1. the plan may make a cash refund to each Medicare beneficiary member;
2. the plan may reduce premium charges to Medicare beneficiary enrollees the following year; or
3. the plan may use the funds to improve or increase medical care services to its Medicare beneficiary members.

Interim and Final Payments

Group practice prepayment plans usually receive premiums from all members in advance of rendering medical services. The Social Security Administration therefore makes available to a plan monthly interim payments, on a per capita basis, for its beneficiary enrollees. The capitation amount is based on cost data derived from the preceding year, and adjusted at the close of its accounting year for any differences anticipated in the current year. A plan submits to SSA appropriate financial reports showing total actual costs for allowable benefits, and the proportionate share of these costs applicable to covered medical services provided or made available to Medicare enrollees. After subtraction of the total annual deductible for all enrolled beneficiaries, 80 per cent of the resulting balance represents the total liability of the Social Security Administration to the group practice prepayment plan. Any difference between SSA's total liability and the total of interim payments represents either an underpayment that is due to the plan,

or an overpayment due from the plan. Such adjustment is made within a reasonable time after the end of the accounting year. The final accounting is subject to audit by or on behalf of the Social Security Administration.

Reimbursement for Provider Services

The term "provider services" refers to the HI (Part A) program. The term includes inpatient hospital care, post-hospital extended care service, and post-hospital home health care. It does not include physician services under Part B, the supplementary medical insurance part of the Medicare program.

A few group practice prepayment plans own and operate their own provider facilities which furnish covered services to its beneficiary members. Assuming the provider of services has entered an agreement with the Secretary of the Department of Health, Education, and Welfare to participate in the Medicare program, reimbursement for care to beneficiary enrollees is determined according to the principles applicable to providers of services generally. In other words, the costs of provider services are computed and reimbursed *separately* from the plan's per capita reimbursement for Part B medical and other health services.

Other group practice prepayment plans have arrangements with participating providers of services to furnish care to plan members, with the plan paying for the cost of such care on a contract basis. However, for Medicare beneficiaries enrolled in the plan, the provider and not the plan is reimbursed for Part A services.

Conclusions

The development and refinement of the methods that have been described for reimbursement of the GPPPs is a continuing process involving the SSA

and the plans themselves. The primary objective has been to make these reimbursement methods as responsive as possible to the variety of group practice prepayment plan arrangements for the provision of medical care services.

Despite these efforts, it has not been possible to accommodate all of the plans in every respect. Some plans—those that have provided or arranged and paid for all or a portion of the services covered under the HI program—believe that the legislative requirement (that the provider and not the plan is reimbursed by Medicare) is inefficient, uneconomical, and unnecessarily burdensome on enrollees. Moreover, it conflicts with their usual mode of operation. The 1967 Amendments to the Social Security Act make it possible to develop experiments with alternative methods of reimbursement. High priority has been given to the development and testing of alternatives designed to increase efficiency and economy.

It is not yet possible to provide reasonably complete data on the experience, either from a cost or a utilization standpoint, of the Medicare enrollees served by the GPPPs. The monthly per capita payments to the individual plans, which are based on the methods for determining estimated costs described earlier, have been adjusted at least once for all plans since the initial fiscal period. These per capita payments vary considerably among the plans. As expected, those plans providing the full range of covered medical care services receive higher per capita payments than plans providing less comprehensive services. For the comprehensive service plans, payments have averaged close to the value of the premium for each period. The three largest plans, which have 83.5 per cent of all GPPP enrollees, received 89.5 per cent of total payments made to GPPPs between July 1, 1966, and September 30, 1968.

Information is not yet available on

the extent to which GPPP enrollees have used covered services provided by physicians outside the plans on a fee-for-service basis for which they may claim reimbursement by the area carrier. While it is unlikely that the extent of such use would add as much as 20 per cent to plan costs for SMI covered services, a 10 per cent additional cost for such use is quite possible.

Of equal interest is the extent of use by GPPP enrollees of HI covered services. Again, data on a person-use basis are not yet available. It can be assumed, however, that those aged who had been enrolled in a GPPP prior to July 1, 1966, or those who became 65 years old since that date, were hospitalized as the need arose. It can be expected that these enrollees would continue to use hospital services at about the same rate as prior to Medicare. To the extent that GPPPs enrolled aged beneficiaries for the first

time following the advent of Medicare, a relatively higher need for hospital services by these enrollees might be expected both because of prior unmet need and their older age. However, only one plan enrolled a significant number of aged persons.

On the basis of a number of previous studies of the use of in-hospital services by members of GPPPs, it can be anticipated that their rate of use of hospital bed days will be about 30 per cent less than that for all other Medicare beneficiaries.

In the near future, it will be possible to combine for enrollees of GPPPs their total utilization of both HI and SMI covered services. If the assumptions just stated are correct, net total program costs for GPPP enrollees should be less than for other enrollees, despite their apparently higher costs for SMI covered services.

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II. THE IMPACT OF MEDICARE ON GROUP PRACTICE PREPAYMENT PLANS

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GROUP Practice Prepayment Plans (GPPPs) are organizations formed by consumers, industry, or unions to provide service through a group of physicians to an enrolled population for a monthly premium payment. Since the

plans form in a variety of ways to meet the needs of different types of population, each plan has its own unique characteristics, and generalizations concerning them are difficult and can be misleading. For purposes of discussion, the